

		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044875

Facility Name: WEST ROCHELLE NURSING & REHAB

Address: 900 N. 3RD STREET ROCHELLE 61068
Number City Zip Code

County: OGLE

Telephone Number: (847) 470-0000 Fax # (847) 470-0061

IDPA ID Number: 36-4326471

Date of Initial License for Current Owners: 06/01/00

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) LEO FEIGENBAUM
(Title) MANAGER

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WEST ROCHELLE NURSING & REHAB

0044875 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>50</u>	Skilled (SNF)	<u>50</u>	<u>18,250</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>50</u>	TOTALS	<u>50</u>	<u>18,250</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>319</u>	<u>1,037</u>	<u>3,728</u>	<u>5,084</u>	8
9	SNF/PED					9
10	ICF	<u>6,061</u>	<u>4,149</u>	<u>77</u>	<u>10,287</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,380</u>	<u>5,186</u>	<u>3,805</u>	<u>15,371</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.22%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 06/01/00

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 6/1/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 25 and days of care provided 3,728

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number WEST ROCHELLE NURSING & REHAB # 0044875 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	114,721	7,250	3,981	125,952		125,952	0	125,952			1
2	Food Purchase		63,336		63,336		63,336	(524)	62,812			2
3	Housekeeping	34,583	9,630	0	44,213		44,213	0	44,213			3
4	Laundry	48,694	6,920	0	55,614		55,614	0	55,614			4
5	Heat and Other Utilities			61,115	61,115		61,115	0	61,115			5
6	Maintenance	37,253	13,400	20,856	71,509		71,509	(2,520)	68,989			6
7	Other (specify):*			11,573	11,573		11,573	0	11,573			7
8	TOTAL General Services	235,251	100,536	97,525	433,312	0	433,312	(3,044)	430,268			8
	B. Health Care and Programs											
9	Medical Director	0		17,320	17,320		17,320	0	17,320			9
10	Nursing and Medical Records	731,847	54,959	14,644	801,450		801,450	0	801,450			10
10a	Therapy	106,742	3,395	0	110,137		110,137	0	110,137			10a
11	Activities	59,780	3,140	3,936	66,856		66,856	0	66,856			11
12	Social Services	4,150		125	4,275		4,275	0	4,275			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			175	175		175	0	175			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	902,519	61,494	36,200	1,000,213	0	1,000,213	0	1,000,213			16
	C. General Administration											
17	Administrative	62,605		78,418	141,023		141,023	2,902	143,925			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			26,229	26,229		26,229	0	26,229			19
20	Dues, Fees, Subscriptions & Promotions			38,599	38,599		38,599	(27,244)	11,355			20
21	Clerical & General Office Expenses	31,386	11,455	32,461	75,302		75,302	(3,998)	71,304			21
22	Employee Benefits & Payroll Taxes			192,672	192,672		192,672	0	192,672			22
23	Inservice Training & Education			787	787		787	0	787			23
24	Travel and Seminar			0	0		0	19	19			24
25	Other Admin. Staff Transportation			380	380		380	40	420			25
26	Insurance-Prop.Liab.Malpractice			55,922	55,922		55,922	220	56,142			26
27	Other (specify):*			25,000	25,000		25,000	(23,935)	1,065			27
28	TOTAL General Administration	93,991	11,455	450,468	555,914	0	555,914	(51,996)	503,918			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,231,761	173,485	584,193	1,989,439	0	1,989,439	(55,040)	1,934,399			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,331	7,331		7,331	(3,790)	3,541			30
31	Amortization of Pre-Op. & Org.			200	200		200	0	200			31
32	Interest			24,863	24,863		24,863	0	24,863			32
33	Real Estate Taxes			19,914	19,914		19,914	0	19,914			33
34	Rent-Facility & Grounds			106,534	106,534		106,534	0	106,534			34
35	Rent-Equipment & Vehicles			10,054	10,054		10,054	2,417	12,471			35
36	Other (specify):* Comp Software			6,968	6,968		6,968	0	6,968			36
37	TOTAL Ownership			175,864	175,864	0	175,864	(1,373)	174,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		271	73,459	73,730		73,730	0	73,730			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			27,375	27,375		27,375	0	27,375			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	271	100,834	101,105	0	101,105	0	101,105			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,231,761	173,756	860,891	2,266,408	0	2,266,408	(56,413)	2,209,995			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,790)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(524)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(341)	21		18
19	Entertainment	0	20		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,000)	27		24
25	Fund Raising, Advertising and Promotional	(27,065)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(2,520)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,490)		\$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	3,077		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,077		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (56,413)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0044875

Report Period Beginning:01/01/2001

Ending:12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ -2520	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,520)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WEST ROCHELLE NURSING & REHAB

0044875

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(524)	0	0	0	0	0	0	0	0	0	0	(524)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,520)	0	0	0	0	0	0	0	0	0	0	(2,520)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,044)	0	0	0	0	0	0	0	0	0	0	(3,044)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	2,902	0	0	0	0	0	0	0	0	0	2,902	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(27,315)	71	0	0	0	0	0	0	0	0	0	(27,244)	20
21	Clerical & General Office Expenses	(341)	(3,657)	0	0	0	0	0	0	0	0	0	(3,998)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	19	0	0	0	0	0	0	0	0	0	19	24
25	Other Admin. Staff Transportation	0	40	0	0	0	0	0	0	0	0	0	40	25
26	Insurance-Prop.Liab.Malpractice	0	220	0	0	0	0	0	0	0	0	0	220	26
27	Other (specify):*	(25,000)	1,065	0	0	0	0	0	0	0	0	0	(23,935)	27
28	TOTAL General Administration	(52,656)	660	0	0	0	0	0	0	0	0	0	(51,996)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,700)	660	0	0	0	0	0	0	0	0	0	(55,040)	29

Summary B

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		LEAF MANAGEMENT		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	17	MANAGEMENT FEES	\$ 52,185	LEAF MANAGEMENT, INC.		\$	(52,185)	1
2	V	21	OUTSIDE CLERICAL	10,133				(10,133)	2
3	V	17	MANAGEMENT FEES				55,087	55,087	3
4	V	20	DUES & SUBSRIPTIONS				71	71	4
5	V	21	CLERICAL				6,476	6,476	5
6	V	27	PAYROLL TAXES				1,065	1,065	6
7	V	24	TRAINING & SEMINARS				19	19	7
8	V	25	AUTO EXPENSE				40	40	8
9	V	26	GENERAL INSURANCE				220	220	9
10	V	35	AUTO LEASE/OFFICE RENT				2,417	2,417	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 62,318			\$ 65,395	\$ * 3,077	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WEST ROCHELLE NURSING & REHAB # 0044875 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LEO FEIGENBAUM	managing member	adm. Banking	14.32	see attached			manmnt fees	\$ 27,543	17-8	1
2			a/r								2
3	ELISHA ATKIN	managing member	ADM. , BANKING	14.32	see attached						3
4			PURCHASES					manmnt fees	27,544	17-8	4
5											5
6	JOEL ATKIN	managing member	ADM BANKING	14.32	see attached			manmnt fees	23,177	17-8	6
7											7
8	NOAH WOLF	managing member		26.61	see attached			manmnt fees	3,056	17-8	8
9											9
10	COLLETTE SMART	ADMINISTRATOR	ADMINISRATIO	2.42	0	1880	100.00	ADMIN. SAL.	62,605	17-1	10
11											11
12											12
13								TOTAL	\$ 143,925		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WEST ROCHELLE NURSING & REHAB # 0044875 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization LEAF MANAGEMENT,INC.
Street Address 9777 GREENWOOD
City / State / Zip Code NILES,IL.60714
Phone Number (847)470-0000
Fax Number (847)470-0061

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	MANAGEMENT FEES	DIRECT	1	1	\$ 55,087	\$	1	\$ 55,087	1
2	20	DUES & SUBSRIPTIONS	PER PATIENT DAY	183,195	4	848		15,371	71	2
3	21	CLERICAL	PER PATIENT DAY	183,195	4	77,180	53,980	15,371	6,476	3
4	27	PAYROLL TAXES	PER PATIENT DAY	183,195	4	12,698		15,371	1,065	4
5	24	TRAINING & SEMINARS	PER PATIENT DAY	183,195	4	225		15,371	19	5
6	25	AUTO EXPENSE	PER PATIENT DAY	183,195	4	474		15,371	40	6
7	26	GENERAL INSURANCE	PER PATIENT DAY	183,195	4	2,617		15,371	220	7
8	35	AUTO LEASE/OFFICE RENT	PER PATIENT DAY	183,195	4	28,811		15,371	2,417	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 177,940	\$ 53,980		\$ 65,395	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL				170,000	170,000	REVOLV	PRIME +	7,714	6
7	INSURANCE FINANCING											3,027	7
8	Shareholders/Partners	X						171,080	171,080			14,122	8
9	TOTAL Facility Related						\$	341,080	\$	341,080			9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	0	\$	0			14
15	TOTALS (line 9+line14)						\$	341,080	\$	341,080			15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WEST ROCHELLE NURSING & REHAB COUNTY OGLE

FACILITY IDPH LICENSE NUMBER 0044875

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	06-24-24-179-007	NURSING HOME	\$ 19,878.00	\$ 19,878.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 19,878.00	\$ 19,878.00

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO If so, please complete the following:

1. Total Amount Incurred: 1,000 2. Number of Years Over Which it is Being Amortized: 5 3. Current Period Amortization: 200 4. Dates Incurred: 06/01/00

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1						\$	1
2							2
3	TOTALS					\$ 0	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50				\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF		2000		47,500	1,727	27.5	1,727		2,663	9
10	PUMP		2000		3,189	116	27.5	116		159	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 50,689	\$ 1,843		\$ 1,843	\$ 0	\$ 2,822	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$16,305	\$5,218	\$1,630	\$(3,588)	10	\$2,445	71
72	Current Year Purchases	1,352	270	68	(202)	10	68	72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	\$17,657	\$5,488	\$1,698	\$(3,790)		\$2,513	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$0	\$0	\$0	0		\$0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$68,346	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$7,331	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$3,541	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(3,790)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,335	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ROCHELL PROPERTY LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		50	06/01/00	\$ 106,534	20		3
4	Additions							4
5								5
6								6
7	TOTAL		50		\$ 106,534			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☒ YES ☐ NO Terms: PURCHASE PRICE \$1,200,221 *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 10,054 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning 06/01/00
Ending 05/31/19

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	\$ 110,336
13.	12/31/2003	\$ 113,834
14.	12/31/2004	\$ 117,126

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES
☒ NO

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER AIDE

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$		\$	0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				73,459		73,459	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): laboratory					271			271	13
14	TOTAL			\$		\$ 271	\$ 73,459		\$ 73,730	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$6,970	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	381,568		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,205		6
7	Other Prepaid Expenses	7,884		7
8	Accounts Receivable (owners or related parties)	470,930		8
9	Other(specify): Real Estate Escrow	20,507		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$954,064	\$0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	50,689		15
16	Equipment, at Historical Cost	38,560		16
17	Accumulated Depreciation (book methods)	(21,449)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,000		19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs	(317)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$68,483	\$0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$1,022,547	\$0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$301,849	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	580		28
29	Short-Term Notes Payable	341,080		29
30	Accrued Salaries Payable	112,991		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	8,435		31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,878		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Oak Park Properties	140,596		36
37	Due to Lessor/Prior Owner	20,709		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$946,118	\$0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$0	\$0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$946,118	\$0	46
47	TOTAL EQUITY(page 18, line 24)	\$76,429	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$1,022,547	\$0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 50,006	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 50,006	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	26,423	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 26,423	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 76,429	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,265,929	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,265,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	26,902	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 26,902	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 0	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,292,831	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	433,312	31
32	Health Care	1,000,213	32
33	General Administration	555,914	33
	B. Capital Expense		
34	Ownership	175,864	34
	C. Ancillary Expense		
35	Special Cost Centers	73,730	35
36	Provider Participation Fee	27,375	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,266,408	40
41	Income before Income Taxes (line 30 minus line 40)**	26,423	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 26,423	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,086	2,410	\$ 60,554	\$ 25.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,709	6,159	133,778	21.72	3
4	Licensed Practical Nurses	7,661	8,044	147,379	18.32	4
5	Nurse Aides & Orderlies	29,150	30,383	358,524	11.80	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,585	4,949	106,742	21.57	8
9	Activity Director	1,949	2,287	35,144	15.37	9
10	Activity Assistants	2,247	2,340	24,636	10.53	10
11	Social Service Workers	271	285	4,150	14.56	11
12	Dietician					12
13	Food Service Supervisor	1,957	2,198	32,010	14.56	13
14	Head Cook	4,415	4,862	47,398	9.75	14
15	Cook Helpers/Assistants	3,287	3,622	35,313	9.75	15
16	Dishwashers					16
17	Maintenance Workers	3,748	3,934	37,253	9.47	17
18	Housekeepers	4,100	4,280	34,583	8.08	18
19	Laundry	4,080	4,351	48,694	11.19	19
20	Administrator	1,880	2,086	62,605	30.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,280	2,363	31,386	13.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,839	2,185	31,612	14.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	81,244	86,738	\$ 1,231,761 *	\$ 14.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MO. FEES	\$ 3,981	1-3	35
36	Medical Director	MO. FEES	17,320	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MO. FEES	3,936	11-3	44
45	Social Service Consultant	MO.FEES	125	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,362		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	93	\$ 3,504		50
51	Licensed Practical Nurses	32	1,740		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	125	\$ 5,244		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
COLLETTE SMART	ADMIN	2.42	\$ 62,605	Workers' Compensation Insurance		\$ 34,756	IDPH License Fee	\$ 200
	ASST ADMIN		0	Unemployment Compensation Insurance		19,997	Advertising: Employee Recruitment	6,371
				FICA Taxes		89,173	Health Care Worker Background Check	84
				Employee Health Insurance		41,196	(Indicate # of checks performed)	
				Employee Meals		0	MARKETING/ADV/PROMO	27,065
				Illinois Municipal Retirement Fund (IMRF)*			RELATED PARTY-DUES	71
				EMPLOYEE BENEFITS - OTHER		7,030	CONTRIBUTIONS	250
				EMPLOYEE PHYSICAL EXAMS		520	DUES & SUBSCRIPTIONS	3,286
				PENSION/PROFIT SHARING PLANS		0	LICENSES & PERMITS	1,343
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	LESS CONTRIBUTIONS	(250)
(List each licensed administrator separately.)			\$ 62,605	INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(27,065)
Description			Amount				Yellow page advertising	(0)
JOEL ATKIN			\$ 23,177					
NEM			3,056					
LEAF			52,185					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 78,418	TOTAL (agree to Schedule V, line 22, col.8)		\$ 192,672	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,355
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SEE ATTACHED			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							Seminar Expense	
								19
							Entertainment Expense	()
SEE SCHEDULE ATTACHED			26,229				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 19
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 26,229					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2001	\$ 3,024	3 YRS	\$	\$	\$	\$ 504	\$ 1,008	\$ 1,008	\$ 504	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,024		\$	\$	\$	\$ 504	\$ 1,008	\$ 1,008	\$ 504	\$	\$

Facility Name & ID Number WEST ROCHELLE NURSING & REHAB

0044875

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 219 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 27,375
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	3,981
	REPAIRS & MAINTENANCE	0
		0
		3,981
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	23,262
	ELECTRICITY	20,471
	WATER	13,946
	CABLE TV - LOBBY	3,436
		0
		61,115
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,701
	PAINTING & DECORATING	3,024
	BUILDING REPAIRS	830
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	10,514
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	1,540
	EXTERMINATING SERVICE	1,440
	FIRE SERVICE	1,807
		0
		0
		0
		20,856
7	OTHER	
	SCAVENGER	11,573
	SECURITY SERVICE	0
		11,573
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	17,320
		17,320

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	5,244
	LABORATORY & XRAY EXPENSE	8,781
	PURCHASED SERVICES	169
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	450
		0
		14,644
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,936
		0
		3,936
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	125
	SOCIAL WORKER XVIII B 45-2	0
		0
		125
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	175	175
17	ADMINISTRATIVE		
	MANAGEMENT FEESXIX B	78,418	78,418
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSINGXIX C	5,139	
	ADMINISTRATIVE CONSULTANTSXIX C	0	
	PROFESSIONAL FEESXIX C	21,090	
		0	26,229
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETINGVI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATEDVI 25 XIX F	27,065	
	EMPLOYEE WANT ADSXIX F	6,371	
	CONTRIBUTIONSVI 20 XIX F	250	
	DUES & SUBSCRIPTIONSXIX F	3,286	
	LICENSES & PERMITSXIX F	1,543	
	PUBLIC RELATIONS-PATIENT RELATEDXIX F	0	
	ADVERTISING-YELLOW PAGESVI 28 XIX F	0	
	CONTRIBUTIONS - POLITICALVI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECXIX F	84	38,599
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES	36	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	12,064	
	PENALTIES / OVERDRAFT CHARGESVI 18	341	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	19,201	
	MESSENGER SERVICE	819	
		0	32,461

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXESXIX D	89,173	
	UNEMPLOYMENT COMPENSATIONXIX D	19,997	
	WORKERS COMPENSATION INSURANCXIX D	34,756	
	HOSPITALIZATION INSURANCEXIX D	41,196	
	EMPLOYEE BENEFITS - OTHERXIX D	7,030	
	EMPLOYEE PHYSICAL EXAMSXIX D	520	
	INSURANCE - EXECUTIVE LIFEVI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANSXIX D	0	
	CHICAGO HEAD TAXXIX D	0	192,672
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	787	787
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARSXIX G	0	
	TRAVELXIX G	0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	380	380
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	55,922	55,922
27	OTHER		
	BAD DEBTSVI 24	25,000	
		0	25,000

GRAND TOTAL COLUMN 3 OTHER

584,193

WEST ROCHELLE NURSING & REHAB
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	63,336	PATIENT MEALS	46113
LESS SALES TAX	(524)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	63860	TOTAL MEALS/YEAR	46113
TOTAL PATIENT CENSUS	15,371	NET FOOD	63860
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	46113

TOTAL PATIENT MEALS	46113	COST PER MEAL	1.38
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		